unsafe abortion, improved and expanded family planning services must be given the highest priority. Twelve years after the Cairns conference, the contraceptive prevalence in Nigeria is 7.3%. This is worse for adolescents and unmarried women who are frequently excluded from contraceptive services. In many developing countries, lack of information on sexuality and contraception is the main barrier. The adolescent population has often translated into a high prevalence of unwanted pregnancy. Thus, there is great need for the establishment of accessible and affordable youth-friendly centres, different from a hospital setting, where these vulnerable groups can go for care. Such centres should be equipped to offer services on family planning counselling and education on reproductive physiology and overall safer sex, and should be able to provide post-abortion care services. Also, regulations, policies and/or laws that restrict adolescents’ access to such services should be revised.

In conclusion, the contribution of unsafe abortion to maternal mortality will be drastically reduced if not completely eliminated if specific and goal-directed actions are taken. Such actions include promoting women’s rights, status and health; ensuring access to contraception; providing general health services, including family planning; putting referral systems in place; and decriminalising abortion and changing laws where they are restrictive. All relevant agencies are called upon to initiate authentic programmes that will curb this carnage from unsafe abortion as part of the overall strategy for achieving the millennium development goal, not only in Nigeria but also in most developing countries of the world.

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References

Cytology sampling using brushes
I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

As an experienced cervical sample taker I agree with Dr Neoh that when sampling the cervix using the Cervex Brush® caution is required when the client has an intrauterine device or intracervical system (IUD/IUS) in situ to ensure the clinician does not inadvertently remove the IUD during sampling.

However, I must point out that the plastic fronds of the brushes are bevelled for clockwise rotation only. The Cervex Brush should be rotated five times in a clockwise direction and not, as stated by Dr Neoh, “five times clockwise and five times anti-clockwise”. This is incorrect sampling and there is also more risk of the threads becoming entangled.

When presented with the above situation, my practice is to rotate the Cervex-Brush five times in a clockwise direction, but to do it in two stages, namely after rotating twice, stop, remove the brush from the cervix (but not from the vagina) and from any threads that may be starting to become entangled, and then continue sampling to complete the five rotations, ensuring the brush is repositioned at the same point on the cervix where the second rotation finished. I have found that although the threads may start to become entangled, it is easy to remove the brush from them without dislodging the IUD.

Using a Spencer Wells forceps as suggested by Dr Neoh is also an option but this requires some skill and may dislodge the IUD/IUS by the traction on the threads. This also necessitates having a ready supply of instruments.

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Cytology sampling using brushes
I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

I would like to question the technique of collecting a cervical cytopathology sample using the new liquid-based cytology (LBC) Cervex Brush® described by the author. The National Health Service Cervical Screening Programme (NHSCSP) guidance2 on taking samples for LBC recommends that the Cervex brush is rotated five times at the external cervical os ‘clockwise only’. Perhaps the technique described by the author that involves rotating the brush at the cervical os five times clockwise and anticlockwise may have inadvertently caused downward traction on the threads of the intrauterine device leading to its ‘unintentional removal’. I do not see any benefit in using a Spencer Wells forceps as suggested by the author to minimise this risk. In fact, I wonder how one could rotate the Cervex brush with the Spencer Wells forceps near the external cervical os and that this technique may be a potential cause for inadequate sampling of the cervix.

I would appreciate readers’ comments.

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Increase in IUD expulsions
It was with great interest, and a sense of déjà-vu, that I read the recent correspondence concerning insertion problems with the Levonorgestrel T380S IUD. Reading Dr Yadava’s original letter in 1996 it enabled me to identify the cause of the problems that I had been experiencing with insertion, and following my adoption (cutting the introducer tube shorter) I experienced no further problems.

It was unfortunate that the manufacturer (in this country at least)3 was not made aware of the problem, and that the apparent design problem has been passed on to newer devices.

In the light of this new evidence, I would like to reiterate my suggestion2 that it might be appropriate for the Faculty to take up the matter with the manufacturer.

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References

Letters to the editor

Unsafe abortion, improved and expanded family planning services must be given the highest priority. Twelve years after...
Cerazette and HRT

Deborah J Lee

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doi: 10.1783/147118907781004967

Updated information and services can be found at:
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